FBMC
BENEFITS MANAGEMENT

Attention
Mailslot 32

DIRECT BILL, P.O. Box 10789, Tallahassee, FL 32302-2789.

RETIREE ENROLLMENT FORM

Plan Year 2016
July 1, 2015 - June 30, 2016

STATE OF WEST VIRGINIA
Mountaineer Retiree Benefits

PLEASE PRINT USING A BALLPOINT PEN.

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SOCIAL SECURITY #	EFFECTIVE DATE (First day of month)	☐ OPEN ENROLLMENT ☐ NEW RETIREE ☐ OTHER	Choose one: ☐ Pay by check (includes TIAA-CREF)* ☐ Deduct from CPRB Retirement check**

LAST NAME (RETIREE OR SURVIVING SPOUSE)	FIRST NAME (RETIREE OR SURVIVING SPOUSE)	MI

MAILING ADDRESS [STREET]

CITY	STATE	ZIP	BIRTH DATE	☐ MALE ☐ FEMALE

HOME PHONE	☐ MARRIED ☐ SINGLE ☐ SURVIVING SPOUSE	E-MAIL

* If you choose to pay by check, you will receive premium coupons for you to mail in your monthly premium.

** If you choose deductions through CPRB, your check deduction will pay for the following month's premium. Example: June deduction will pay the July premium. You will receive premium coupons for you to mail in your monthly premium until CPRB deductions begin.

2 INSTRUCTIONS

You do not need to complete the form if you wish to continue your current retiree benefits without changes. New retirees or surviving spouses must complete this application to enroll for coverage. However, if you enroll or make changes, mail the form to FBMC/Direct Bill, P.O. Box 10789, Tallahassee, FL 32302-2789. Please complete the dependent information section if you select coverage that includes dependents.

3 MOUNTAINEER RETIREE BENEFITS

Monthly Retiree Rates

DELTA DENTAL	ROUTINE	ASSISTANCE	BASIC	ENHANCED
☐ Cancel Dental Coverage	☐ Retiree Only $9.68 ☐ Retiree & Children* $19.41 ☐ Retiree & Spouse* $21.65 ☐ Retiree & Family* $31.43	☐ Retiree Only $10.46 ☐ Retiree & Children* $20.97 ☐ Retiree & Spouse* $23.39 ☐ Retiree & Family* $33.95	☐ Retiree Only $17.95 ☐ Retiree & Children* $35.95 ☐ Retiree & Spouse* $40.06 ☐ Retiree & Family* $58.10	☐ Retiree Only $29.85 ☐ Retiree & Children* $59.71 ☐ Retiree & Spouse* $69.33 ☐ Retiree & Family* $99.04

METLIFE VISION	EXAM PLUS	FULL SERVICE
☐ Cancel Vision Coverage	☐ Retiree Only $1.15 ☐ Retiree & Family* $2.61	☐ Retiree Only $6.67 ☐ Retiree & Family* $16.97

EPIC HEARING SERVICE				
☐ Cancel Hearing Coverage	☐ Retiree Only $1.75	☐ Retiree & Children* $2.60	☐ Retiree & Spouse* $3.56	☐ Retiree & Family* $4.40

HYATT LEGAL	
☐ Cancel Legal Coverage	☐ Retiree & Family* $16.50

*IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

4 DEPENDENT INFORMATION

USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED			
					DENTAL	VISION	HEARING	LEGAL
	SPOUSE							

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed. For Retirees who did not elect to have premiums deducted from CPRB: I agree to remit payment to FBMC Benefits Management.

RETIREE SIGNATURE	DATE SIGNED